

# Body dysmorphic disorder and the ugly truth of Australian healthcare

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How well do you know body dysmorphic disorder (BDD)? This mental disorder involves a distressing or impairing preoccupation with a perceived defect in physical appearance, associated with excessive or repetitive behaviours or mental acts aimed at camouflaging, checking or ‘improving’ the perceived area of concern. BDD is relatively common, affecting at least 2% of the population worldwide, with rates being highest (4.4%) among young adults and adolescents. Yet, international data suggest that BDD is poorly recognised by health professionals, and as a result, patients may not receive timely or appropriate care (Castle et al., 2021). Our observations, ascertained through over 20 years of working with BDD, suggest similar challenges exist here in Australia. Research data and the countless anecdotes presented to us by research participants and patients with BDD all point to a silent and significant unmet need in the appropriate diagnosis and treatment of BDD in Australia.

Our clinical clients and research participants have often said that obtaining a BDD diagnosis was a challenging or protracted process. Among our most recently surveyed group of 28 adults with BDD (seen from 2018 to 2020), only 19.2% were diagnosed in the same year of symptom onset, and 38.5% were diagnosed 1–5 years after onset. Worryingly, 19.2% received a diagnosis 5–10 years following onset, while 23.1% were diagnosed 10–29 years after onset. While longer delays were prevalent among older adults, who likely faced a complete

lack of BDD awareness in previous decades, delays were not exclusive to this group. Indeed, just under half (45%) of the young adult participants (aged 18–25 years) reported enduring symptoms for 4–10 years before receiving a diagnosis. But what causes such delays? We perceive the problem to be twofold, the first involving patient-related barriers to help-seeking – including shame and poor public awareness of BDD – and the second reflecting practitioner-related challenges in accurately detecting BDD.

From the lived experience side, participants have described avoiding or delaying seeking help for their BDD symptoms due to feelings of shame. Shame is a core characteristic of BDD, and shame-driven fears of being seen as vain or narcissistic, or of having their appearance concerns trivialised or ridiculed, are commonly cited barriers to seeking help (Marques et al., 2011). Other patients described delaying seeking mental health support because they were unaware that their experiences might be explained by a mental health condition. This unawareness could reflect poor public knowledge of BDD and/or low illness insight (i.e. strong conviction that perceived appearance flaw(s) reflect an objective physical reality). Increased public awareness regarding BDD is sorely needed to foster better recognition of symptoms among affected individuals and/or those close to them and support normalisation of help-seeking behaviours in this group. For instance, we sometimes hear from participants that happening upon a television programme featuring BDD, or

information about BDD on the Internet, led them to realise that they might have a disorder for which they could obtain psychological/psychiatric support. Other participants had never heard of BDD until they received their diagnosis. With increased awareness, affected individuals or their close loved ones might be better able to recognise the signs of BDD, leading to earlier contact with mental health services.

Regarding poor insight, conviction in appearance concerns as having a physical basis can lead patients to try and ‘fix’ or ‘improve’ the perceived flaw through physical means, resulting in presentation to cosmetic settings (e.g. dermatology, cosmetic dental, plastic surgery or aesthetic practices) instead of mental health settings. Our recent Melbourne-based data suggest that 5–25% of individuals seeking consultation for cosmetic procedures (surgical and non-surgical) were likely to have BDD (Pikoos et al., 2021). However, there are no comprehensive Australian data to indicate how often people seeking such procedures ultimately receive a BDD diagnosis.

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**Table 1.** Example questions for practitioners based upon the latest DSM-5 criteria.

1. Do you have any concerns about your appearance or how you look?
2. How much time would you estimate you spend worrying about your appearance?
3. Is there anything that you do repeatedly to check, fix or hide or be reassured by your appearance?
4. Do these concerns cause you distress or interfere with your life in any way?

Delays in receiving a timely diagnosis of BDD are also influenced by practitioner-related barriers. We have heard from participants that healthcare practitioners, including psychiatrists, but most often those in primary care settings (e.g. general practitioners [GPs]), often missed opportunities to enquire about symptoms of the disorder. As a result, approximately 40% of our most recent group of BDD participants walked away from their initial consultation in which they disclosed their BDD symptoms with either no diagnosis or a diagnosis for depression, social anxiety, obsessive-compulsive disorder (OCD) or unspecified eating disorder, but not BDD. We suggest that all practitioners proactively enquire about appearance concerns in patients presenting for mental health distress and to treat any disclosures of concern with empathy and gravity. GPs are the most likely healthcare specialty to be involved in initial disclosures. Particular psychiatric 'high-risk' groups for comorbid BDD include people with eating disorders, social anxiety disorder, 'atypical' depression and

OCD. Brief validated screening scales such as the Dysmorphic Concern Questionnaire (Mancuso et al., 2010) can be used to probe for clinically significant symptoms. However, in time-limited consultations careful structured questioning guided by DSM criteria should be used to accurately delineate BDD from other conditions (see Table 1 for examples). Thus, we recommend all healthcare disciplines to familiarise themselves with the DSM criteria and the questions we have provided in Table 1.

Given that people with BDD so frequently seek cosmetic procedures, it is critical that such practitioners can accurately recognise clients with BDD and redirect them to mental health services. Research shows that cosmetic procedures typically provide no psychological relief or can even worsen symptoms, and thus should generally be avoided (Castle et al., 2021). We are aware of no Australian data regarding cosmetic practitioner's awareness of BDD. However, recent UK data showed only 20% of clinicians asked potential clients about body image or psychological/emotional challenges,<sup>1</sup> and thus similar patterns may also exist in Australia.

Finally, our research participants have expressed desperation and hopelessness with the available treatment services. Participants describe not being able to find appropriate care except from a handful of specialists, while others have described hearing their doctors say that they 'don't know how to help' them, or of having to print out and bring their own 'BDD information' to unaware physicians. Some have described being prescribed unhelpful treatments or therapies that

were initially developed for OCD, depression or anxiety disorders, without nuanced prescribing for the specific needs of people with BDD (see Castle et al., 2021). Others tell of having to travel a very long way, or enduring lengthy waiting lists for months or years, just to see a BDD-informed clinician. As a result, many participants we see have been unwell for a long time and have frequently reached crisis point, leading to suicide attempts and psychiatric hospitalisations. Among our recent group of 28 research participants, one-fifth had made a suicide attempt specifically because of BDD-related distress, and more than half endorsed current suicidal ideation.

Clearly, there is much to be done in improving access to timely and appropriate healthcare services for people with BDD. Better training of mental health professionals and GPs in recognising and treating BDD will be critical in alleviating this crisis, supported by improving public literacy around BDD. It is our long-term goal to establish 'The Aurora Centre' – a centre that will deliver much-needed training and resources for clinicians and cosmetic practitioners to develop their awareness of and competency in managing BDD, can champion large-scale public awareness campaigns and will generate high-quality translational science for enhanced treatments (major gaps have been outlined in Table 2). As we strive towards this goal, we call upon practitioners to take a greater awareness of BDD using the recommendations of recently published expert consensus on best-practice clinical management of BDD (Castle et al., 2021), and by following BDD-specific treatment

**Table 2.** Key knowledge gaps in relation to BDD.

1. Lack of knowledge about BDD in the general public, thus better public health campaigns needed.
2. Poor prevalence data regarding BDD in Australia, both in the general public but more specifically in cosmetic settings.
3. No specific training for mental health and primary practice clinicians as well as those in the cosmetic industry with regard to both recognising BDD symptoms and treating them.
4. No BDD-specific treatment options, therefore more innovative research needed to improve outcomes for those with BDD.

BDD: body dysmorphic disorder.

manuals for highest-quality care (e.g. Wilhelm et al., 2013). As we continue to conduct research into BDD, we hope to hear a shift in the anecdotes of diagnosis and treatment that are relayed to us. Better care for Australians with BDD is possible, but it is long overdue and requires substantial attention.

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### Note

1. <https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/114/report.html>. The survey was completed by the Joint Council for Cosmetic Practitioners. The occupations surveyed were medical doctors (including dermatologists and plastic surgeons), nurses, dentists, allied health professionals (including physiotherapists and podiatrists), as well as cosmetic practitioners from a beauty background (who complete aesthetics procedures that do not involve injections).

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